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http://www.dmas.state.va.us

MEDICAID MEMO

TO: All Long Term Care Providers Participating in the Virginia Medical Assistance Program and Managed Care Organizations (Health Plans)

FROM: Cynthia B. Jones, Director
Department of Medical Assistance Services (DMAS)

MEMO: Special

DATE: 10/4/2017

SUBJECT: Reimbursement for Individuals Evacuated from a Disaster Struck Nursing Facility Due to Temporary Emergencies

The purpose of this memorandum is to clarify Department of Medical Assistance Services' (DMAS) reimbursement policies for Medicaid-enrolled individuals residing in a nursing facility who must temporarily evacuate due to a single facility emergency or large-scale disaster. This policy clarification has been approved by the Centers for Medicare and Medicaid Services (CMS) through a State Plan Amendment, and will be included in the Virginia Long Term Care Mutual Aid Plan (LTC-MAP). This policy does not apply to a non-emergency voluntary or involuntary nursing facility closure.

Recent natural disasters have impacted nursing facilities across the country and have accelerated emergency preparedness planning efforts locally, regionally, and across the Commonwealth. On September 16, 2016, CMS issued Rule 3178F - *Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers*. This final rule establishes national emergency preparedness requirements for Medicare and Medicaid participating providers and suppliers to plan adequately for natural and man-made disasters, and coordinate with federal, state, tribal, regional, and local emergency preparedness systems. The rule became effective on November 15, 2016 and participating facilities must implement these regulations by November 15, 2017.

In order to comply with the Policies and Procedures section of these CMS regulations, Long Term Care (LTC) facilities are required to develop arrangements with other facilities and providers to receive their residents in the event of limitations or the cessation of operations due to an emergency. The Virginia Hospital & Healthcare Association (VHHA) and the Virginia Department of Health (VDH) have created the LTC-MAP to assist LTC facilities with evacuating their residents to another facility during a local or regional disaster. The LTC-MAP will include the following language:

Reimbursement

Reimbursement to a Disaster Struck Facility (DSF) for its Medicaid residents who must be temporarily evacuated to another facility (Resident Accepting Facility - RAF) may continue for up to 30 calendar days following the disaster event.

- The DSF does not "discharge" its residents and the RAF does not "admit" the residents transitioning from the DSF.

- The DSF is still considered the provider of record and will continue to bill Medicaid for each day of care.

- Reimbursement will be the same as if the individual was residing in the DSF.

- The DSF is then responsible for reimbursing the RAF that accepts its residents during the disaster period.

- No other reimbursement will be made to either the DSF or the RAF.

The DSF and RAF must meet the following conditions:

Contract

a. The DSF must have a contract with the RAF, the contract must:
   i. Include terms of reimbursement and mechanisms to resolve any contract disputes;
   ii. Protocols for sharing care and treatment information between the two facilities; and
   iii. Requirements that both facilities meet all conditions of Medicare or Medicaid participation determined by the Virginia Department of Health.

   Note: The Virginia Long Term Care Mutual Aid Plan Memorandum of Understanding is an acceptable contract.

Resident Records

a. The DSF must notify DMAS of the disaster event, maintain records of evacuated residents with names, dates and their evacuation destination, and regularly update DMAS on the status of the repairs to their facility.
   i. The DSF must send the required information by email to evacuation@dmas.virginia.gov or by fax to (804)371-4981.
   ii. Alternatively, the DSF may coordinate with the Regional Healthcare Coordinating Center (RHCC) to provide DMAS with the required information.

b. The DSF is responsible for completing the necessary Minimum Data Set (MDS) assessments, either directly or by delegating the function to the RAF.
   i. The RAF need only complete the clinical assessment portion of the MDS for each evacuated resident, and may do this on a paper MDS form if the electronic MDS is not available.
   ii. The RAF may then send the paper MDS assessment back to the DSF.
   iii. The DSF may transmit the updated MDS at a later date, once the emergency is resolved as long as it was completed timely and within the appropriate observation period.

Note: This process does not require the issuance of the 1135 waiver.[1]

Placement Requirements

a. Nothing shall preclude an individual from asking to be discharged and admitted to another nursing facility or alternative placement during the initial 30-day period. Alternative placements may include:
   i. Home and Community-Based Services Waiver (e.g., CCC Plus waiver), or
   ii. Program for All-Inclusive Care for the Elderly (PACE)

b. The DSF must determine within 15 days of the event whether individuals will be able to return to the facility within 30 days of the disaster event. If the DSF determines that it is not able to reopen within 30 days, it must discharge the individuals and work with them to choose admission to the RAF, other nursing facilities, or alternative placements.

   i. The DSF should proceed with discharge documentation by Day 16 (DMAS does not pay for Day of Discharge) and the RAF should commence with admission procedures by Day 16 for these Medicaid individuals (DMAS doe s pay for day of admission).

      Note: It is understood that it would be impractical to completely discharge all residents from the DSF and admit them to other facilities or placements in one day; therefore, the process should commence by calendar Day 16 and be completed by calendar Day 30.

   ii. Admission to the RAF is not a requirement and it may be deemed that the resident could be transferred to a more suitable location at that time if he or she does not meet the RAF's admission criteria or based on resident choice. In this situation, normal discharge procedures apply.

   iii. The RAF or other facility or placement that accepts admission of evacuated residents must follow normal admission criteria.

   iv. Reimbursement to the DSF shall cease when an individual is officially discharged.

   v. If the resident returns to the DSF after the 30-day timeframe, the RAF or alternate facility will discharge the resident and complete a discharge assessment. The DSF

[1] CMS - Division of Nursing Homes Survey and Certification. Hurricane Irene – SNF/NF and MDS Related Questions. September 1, 2011.

will then consider the resident as a new "admission" (not a "Re-entry") for MDS purposes.[2]

Note: If the RAF does not accept Medicaid, the RAF will not be able to accept residents enrolled in Medicaid from the DSF for formal admission. In this case, a transfer request would be required.

Managed Care Organizations (Health Plans) – The Virginia Long Term Care Mutual Aid Plan will satisfy the requirements referenced in the DMAS Health Plan Contract - Section 12.4.10 – "Nursing Facility Mutual Aid Agreements."

MAGELLAN BEHAVIORAL HEALTH OF VIRGINIA (Behavioral Health Services Administrator)

Providers of behavioral health services may check member eligibility, claims status, check status, service limits, and service authorizations by visiting www.MagellanHealth.com/Provider. If you have any questions regarding behavioral health services, service authorization, or enrollment and credentialing as a Medicaid behavioral health service provider please contact Magellan Behavioral Health of Virginia toll free at 1-800-424-4046 or by visiting www.magellanofvirginia.com or submitting questions to VAProviderQuestions@MagellanHealth.com.

MANAGED CARE PROGRAMS

Most Medicaid individuals are enrolled in one of the Department's managed care programs: Medallion 3.0, Commonwealth Coordinated Care (CCC), Commonwealth Coordinated Care Plus (CCC Plus), and Program of All-Inclusive Care for the Elderly (PACE). In order to be reimbursed for services provided to a managed care enrolled individual, providers must follow their respective contract with the managed care plan/PACE provider. The managed care plan/PACE provider may utilize different prior authorization, billing, and reimbursement guidelines than those described for Medicaid fee-for-service individuals. For more information, please contact the individual's managed care plan/PACE provider directly.

Contact information for managed care plans/PACE providers can be found on the DMAS website for each program as follows:

- Medallion 3.0: http://www.dmas.virginia.gov/Content_pgs/mc-home.aspx
- Commonwealth Coordinated Care (CCC): http://www.dmas.virginia.gov/Content_pgs/mmfa-isp.aspx
- Commonwealth Coordinated Care Plus (CCC Plus): http://www.dmas.virginia.gov/Content_pgs/mltss-proinfo.aspx
- Program of All-Inclusive Care for the Elderly (PACE): http://www.dmas.virginia.gov/Content_atchs/ltc/WEB%20PAGE%20FOR%20PACE%20Sites%20in%20VA.pdf

COMMONWEALTH COORDINATED CARE PLUS

Commonwealth Coordinated Care Plus is a required managed long term services and supports program for individuals who are either 65 or older or meet eligibility requirements due to a disability. The program

[2] CMS - Provider Survey and Certification Frequently Asked Questions, Declared Public Health Emergencies – All Hazards Health Standards and Quality Issues, Section K – Nursing Home Providers. Issued May 21, 2013. Updated March, 2017.

integrates medical, behavioral health, and long term services and supports into one program and provides care coordination for members. The goal of this coordinated delivery system is to improve access, quality and efficiency. Please visit the website at: http://www.dmas.virginia.gov/Content_pgs/mltss-home.aspx.

VIRGINIA MEDICAID WEB PORTAL

DMAS offers a web-based Internet option to access information regarding Medicaid or FAMIS member eligibility, claims status, payment status, service limits, service authorizations, and electronic copies of remittance advices. Providers must register through the Virginia Medicaid Web Portal in order to access this information. The Virginia Medicaid Web Portal can be accessed by going to: www.virginiamedicaid.dmas.virginia.gov. If you have any questions regarding the Virginia Medicaid Web Portal, please contact the Conduent Government Healthcare Solutions Support Help desk toll free, at 1-866-352-0496 from 8:00 a.m. to 5:00 p.m. Monday through Friday, except holidays. The MediCall audio response system provides similar information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider.

KEPRO PROVIDER PORTAL

Providers may access service authorization information including status via KEPRO's Provider Portal at http://dmas.kepro.com.

"HELPLINE"

The "HELPLINE" is available to answer questions Monday through Friday from 8:00 a.m. to 5:00 p.m., except on holidays. The "HELPLINE" numbers are:

1-804-786-6273	Richmond area and out-of-state long distance
1-800-552-8627	All other areas (in-state, toll-free long distance)

Please remember that the "HELPLINE" is for provider use only. Please have your Medicaid Provider Identification Number available when you call.

TO ALL MEDICAID PROVIDERS: PROVIDER APPEAL REQUEST FORM NOW AVAILABLE

There is now a form available on the DMAS website to assist providers in filing an appeal with the DMAS Appeals Division. The link to the page is http://www.dmas.virginia.gov/Content_pgs/appeal-home.aspx and the form can be accessed from there by clicking on, "Click here to download a Provider Appeal Request Form." The form is in PDF format and has fillable fields. It can either be filled out online and then printed or downloaded and saved to your business computer. It is designed to save you time and money by assisting you in supplying all of the necessary information to identify your area of concern and the basic facts associated with that concern. Once you complete the form, you can simply print it and attach any supporting documentation you wish, and send to the Appeals Division by means of the United States mail, courier or other hand delivery, facsimile, electronic mail, or electronic submission supported by the Agency.

PROVIDERS: NEW MEDICARE CARDS ARE COMING

CMS is removing Social Security Numbers from Medicare cards to help fight identity theft and safeguard taxpayer dollars. In previous messages, CMS has stated that you must be ready by April 2018 for the change from the Social Security Number based Health Insurance Claim Number to the randomly generated Medicare Beneficiary Identifier (the new Medicare number). Up to now, CMS has referred to this work as the Social Security Number Removal Initiative (SSNRI). Moving forward, CMS will refer to this project as the New Medicare Card.

To help you find information quickly, CMS designed a new homepage linking you to the latest details, including how to talk to your Medicare patients about the new Medicare Card. Bookmark the New Medicare Card homepage and Provider webpage, and visit often, so you have the information you need to be ready by April 1.

Providers (which includes fee for service, Medicaid Managed Care Organizations, and Commonwealth Coordinated Care Plus) may share the following information with members:

MEMBERS: NEW MEDICARE CARDS ARE COMING

Medicare will mail new Medicare cards between April 2018 and April 2019. Your new card will have a new Medicare Number that's unique to you, instead of your Social Security Number. This will help to protect your identity.

Additional information is available at the following link:
https://www.medicare.gov/forms-help-and-resources/your-medicare-card.html